CENTRAL DISTRICT HEALTH DEPARTMENT

To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

CLIENT INFORMATION FORM

Name (Last) _____ **First** _____ **Middle**_____

Date of Birth _____/_____/_____ **Age** _____ **Gender** Female / Male

Mailing Address _____

City _____**State**_____ **Zip**_____

Residence Address _____
(If different from mailing address)

OPTIONAL

Ethnicity Hispanic / Not Hispanic / Unknown **Race** White / American Indian / Black / Alaskan Native / Asian / Hawaiian—Pac Islander / Other

Language English / Spanish / Other _____ **SS# (optional)** _____

Home Phone _____**Work Phone** _____ **Msg Phone**_____

Parent or Guardian _____**Mother's Maiden Name**_____

At birth were you a: Single / Twin / Triplet / Other Is the patient on the **WIC** program? ____ Yes ____ No

Circle all that apply:*0-18 years of age only*
Medicaid / No Insurance / Insurance / American Indian / Alaskan Native / Underinsured

Optional: Email_____ Cell Phone_____

Primary Insurance Patient's relationship to insured: Self Spouse Child

Insurance Company:_____Name of Primary Insured:_____

Insured Date of Birth:_____Insured Phone:_____

ID#:_____Group #:_____

Insured's address if different from above:_____

Medicaid Information

Name (as printed on card):_____Medicaid #_____

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

_____ I acknowledge that I was given a copy, and I have read, or had explained to me the Central District Health Department Notice of Privacy Practices.

_____ I acknowledge that I was given a copy, and I have read, and understand the Financial and Appointment Policy.

_____ I need financial assistance. (Client must be 18 years of age or younger.)

_____ I understand that childhood immunizations are not mandatory and may be refused on religious or other grounds.

_____ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X_____ DATE _____

********FOR OFFICE USE ONLY********

_____ _____ _____

Revised 7/1/11

MEDICAL SCREENING FOR IMMUNIZATIONS

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask your healthcare provider to explain it.

Is the patient sick today?	YES	NO	NOT SURE
Does the patient have allergies to medications, food, or any vaccine? (For example: eggs) Please list: _____	YES	NO	NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	YES	NO	NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	YES	NO	NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO	NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had x-ray treatments? Long term aspirin therapy? Daily aspirin dose _____.	YES	NO	NOT SURE
During the **past year**, has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	YES	NO	NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the **past four weeks**? If yes, when: month _____ day _____	YES	NO	NOT SURE
Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES	NO	NOT SURE
Has the patient had chickenpox? If yes, when? _____	YES	NO	NOT SURE
Does the patient smoke?	YES	NO	NOT SURE
For females: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO	NOT SURE

CONSENT

I have read or had explained to me the Vaccine Information Statement for the vaccines to be received today. I understand the risks and benefits. **I GIVE CONSENT** to Central District Health Department and its staff for me or my child named on the front of this form to be vaccinated.

Client/Guardian Signature: _____

Relationship to Client: _____ Date: _____

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)